This ethnographic study explores an anomaly in the reproductive health situation of poor rural women in Bangladesh, namely the coexistence of significant fertility reduction at the same time as continued high maternal mortality due to dependency on home deliveries in the absence of skilled health professionals and health complications resulting from unsafe abortions. Inspired by the feminist conceptualization of agency, the study resurrects the importance of considering culture and context in understanding reproductive decisions, as opposed to a rational individualistic notion of agency. Comparison between mainstream patrilineal Bengali and matrilineal-matrilocal indigenous Garos in the same rural location enables the study to demonstrate how complex factors intersect and interact to form gender power structures in shaping reproductive practice.

A combination of the capabilities framework and the social relations framework informed by feminist concepts of gender, agency and empowerment guided the data collection process and analysis of the findings. A village named Gachhabari (Tangail district, Dhaka division), Bangladesh, was purposively selected for its mixed ethnic population of patrilineal Bengali (mainstream Muslims and Hindu minority) and indigenous matrilineal Garo communities. By incorporating women’s “voices” articulated through their own narratives, the study aims to show how poor women from different ethnic backgrounds experience and navigate power at the household, community, market and the state level in relation to their reproductive practice.

The study contends that reproductive health policies and discourses are an outcome of existing power structures. Due to donor dependency, national population policies have been articulated in line with the donor discourse. In the mid-1990s the Bangladeshi population policy adopted a comprehensive reproductive health care approach to ensure health equality and reduce the gap between the rich and the poor. However, the findings of the study point to a more nuanced picture. Multiple interest groups and institutional arms of the state exercise forms of covert power via policies, discourses and knowledge produced by disciplinary institutions to govern the reproductive behaviour of the poor.

The depiction of household poverty as a result of higher fertility among the poor, which in turn pushes households to remain in poverty and results in poor reproductive health, interwoven with the national concern about macro-economic development justifies aligning fertility reduction under macro-economic development goals. Knowledge produced by disciplinary institutions that construct a discursive reality of poor women’s need for long-acting contraception, fosters the interests of a powerful alliance of service providers, international donor and multinational pharmaceutical companies. By offering long-acting (implant) and permanent contraception (sterilization) through an Essential Service Package (ESP) under donor supported “safety net programme” in the public health care system to the poor further shapes the reality by shaping reproductive practice.

The ways in which women’s subject positions are constructed and normalised in policies and discourses, further explains high maternal mortality resulting from the absence of skilled health professionals during childbirth as “the lack of demand for maternal health care services” by the poor. This depiction of poor women as homogenous and powerless victims of culture justifies female focused Maternal Child Health and Family Planning (MCH-FP) programme to ensure health equality. Such a discourse serves the interest of the health care providers by creating demand and supply of reproductive health care goods and services through dual health care systems, private health care for the well-off and public health care system for the poor. Policy discourse remains silent about how privatization of health care in combination with market mechanism, class inequality, gender and ethnic differences created existing health inequality.
Despite being critical of the government policy approach, women’s organizations realize that the availability of contraception and Menstrual Regulation (MR) services, although inspired by population control motives, could be empowering for women provided that women are not integrated under an oppressive gender system. Women’s organisations articulate existing health inequality in relation to women’s subordinate position, patriarchal norms and unequal gender power relations. Yet, a major absence in the mainstream women’s organisations is the tribal women’s voice and in that sense they also treat poor women and their needs as being self-evident and homogenous.

Contrary to the individualistic notion of agency, the study provides insight how a complex interplay between gender, ethnicity and economic forces shape contraception and menstrual regulation/abortion practices. Across all ethnic groups most women take up the contraceptive responsibility for the greater benefit of the household. A stigma attached to vasectomy and men’s role as the breadwinner discourage households to use vasectomy, since households are mainly dependent on men’s labour. Men and women both believe vasectomy reduces men’s physical power. Although the breadwinners’ norm is not equally strong among Garos, they too show reluctance towards vasectomy. A range of concerns including cost, pleasure, safety, gossip, fear of mistrust and rumours create a negative perception towards condoms as expensive, unreliable and inconvenient method of contraception. Ideological restrictions against invasive modern contraception and abortion make Garos more dependent on natural methods and less use of menstrual regulation and abortion services. A more balanced intra-household gender relation is however reflected in proportionately higher condom use among Garos as compared to Bengalis. Older Garo women also showed their agency by using sterilisation, being the only available method in earlier times.

The research findings indicate that the outcome of negotiation does not represent women’s autonomous choice, but that notions of masculinity and femininity are linked to different contraceptive methods to make women take on the contraceptive responsibility along with the side effects. This process is reinforced by female focused family planning programmes, which require minimum involvement from men and further reinforce gender hierarchy by demanding husbands’ consent to use MR service.

Women’s narratives show they are resilient and deploy resources at their disposal to deal with side-effects of contraception by switching between different methods or sending their husbands to get the pill from private market or to get medicine to treat the symptoms. Women also use existing cultural norms to their advantage to assert their claims to exercise their right to use menstrual regulation services, manoeuvre official rules for the time limit or husbands consent to use menstrual regulation service or use secret abortion practices, although this sometimes puts women’s health and wellbeing at risk. This indicates that even if women are able to negotiate in the household to exercise their choice and agency they face constraints in the health care market. This finding resurrects the importance of looking at gender power relations beyond the boundaries of the household in explaining women’s agency in reproductive decisions.

In contrast to the notion of women as ignorant victims of static, rigid cultural norms to explain the low institutional childbirth, the study provided insight how structural factors are enmeshed with cultural factors to render poor women’s access to childbirth, after delivery and other reproductive health care services inaccessible. Women do not mindlessly follow a tradition of home delivery but rather rely on informal Traditional Birth Attendants (TBAs) based on trust, expertise, familiarity, affordability and proximity of the providers. Although cultural norms play a role, hidden cost, doctor’s absenteeism and inadequate quality of care in the public hospital remains a constraint on poor women’s access to reproductive health care services. Poor women also find it difficult to negotiate between their work responsibilities in the household and outside and biological reproduction in favour of their own wellbeing. This is reflected even in rejecting the option of a Caesarean in a complicated delivery, since it could affect their work capacity. This
linkage with women’s responsibilities for household reproduction remains largely invisible in policies and discussions in Bangladesh.

The findings of this study suggest that agency in reproductive behaviour is multifaceted. Questioning the conventional indicators of women’s empowerment, despite enjoying significant autonomy in terms of intra-household gender relations under the matrilineal system, comparatively higher age at marriage, relatively higher education and no restrictions on mobility, the study found matrilineal Garo women use less contraception, rely on home deliveries and experience higher fertility compared to patrilineal Bengalis. Ethnic differences are not only based on cultural elements, but deeply rooted in the structural system which has far reach political and material implication based on inclusion/exclusion in access to resources in the broader social system. Garo ethnic identity is based on the experience of exclusion from the state authority by banning their traditional livelihood systems, denying access to their ancestral land and forest resources and excluding and marginalising them in forest development projects.

Given that socio-economic and political context, Garo women’s choice for relatively high fertility is an outcome of negotiations between their ethnic identity, the desire for daughters to carry on their matrilineal kinship system and the perceived need to increase their numbers due to inter-ethnic tension with dominant Bengalis and political struggle to reclaim their ancestral land. The patronage from the Church which provides security and refuge along with an ideological influence towards larger families contribute to this. Garo women further experience relative economic return from their children due to alternative livelihood opportunities for younger Garo girls and boys created in the NGOs via the Church and other informal sectors. All these contribute to Garo women’s practice of raising somewhat larger numbers of living children as compared to their Bengali counterparts.

Interpreting Bengali and Garo women’s reproductive decisions as rational individualistic choice detached from the cultural context and existing structures of inequality (as neoliberal policy suggests), ignores the complexities of culturally defined conjugal contracts, differences between patrilineal and matrilineal systems as well as the broader political and socio-economic context which shape gender power relation in reproductive decisions.